Department of Veterans Affairs Community Living Center Survey Report

This document or report and the information contained herein, which resulted from the Community Living Center Unannounced Survey, has been de-identified to remove individually identifiable health information (also known as protected health information) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and other federal and state laws. De-Identification was completed in accordance with guidance published by the Office for Civil Rights to protect the privacy of the Community Living Center's residents.

General Information:

Location: Edward Hines Jr. VA Medical Center (Hines, IL)

Dates of Survey: 8/6/2019 to 8/8/2019

Total Available Beds: 146

Census on First Day of Survey: 116

F-Tag	Findings
F166 483.10(f)(2) *A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.* **Level of Harm** - No actual harm with potential for more than minimal harm that is not immediate jeopardy **Residents Affected** - Some	Based on interview and record review, the CLC did not ensure prompt efforts to resolve grievances. Findings include: [LOCATION] • During an interview on 08/06/17, a resident residing in the [LOCATION] neighborhood and who wished to remain anonymous stated, “Sometimes they [staff] give me three knives and no fork or spoon for meals and others [other residents] no knife or fork but only a spoon at meals. Sometimes I get coffee but no cream and other times I get the cream but no coffee at meals. The food is bland. Usually the food is cold, but they [nursing staff] will warm it up in the microwave….I used to go to the Resident Council meetings and complained about the meal service, but I quit going because they [staff] never do anything about our complaints.” • On 08/07/19, another resident residing in the [LOCATION] neighborhood requested to be interviewed and requested anonymity. The resident continually stated, “I don’t want this in my record.” When asked about the restriction preventing residents from getting out of bed between 12:00 p.m. and 2:00 p.m. daily, the resident confirmed the information and indicated that it was “not right.” The resident stated, “I like to go to church on Sundays, but they get other people up before me that do not even go to church and I miss church sometimes. I don’t think that’s right.” The resident stated the food served was “slop.” When asked if the resident attended Resident Council meetings, the resident stated, “Oh, I used to go, but they [staff] never do anything about our concerns, so I quit going.” • A third resident from [LOCATION] who requested not to be identified stated, “Nothing gets done in response to Resident Council concerns. I don’t go there anymore.” *Resident Council Minutes* • The 08/16/18 Resident Council meeting minutes addressed dietary concerns and stated, “Untimely delivery of food trays to RCF [Resident Care Facility] unit. Residents reported that food received for meal is different than food items selected on menu.” The meeting minutes indicated five residents from [LOCATION] attended the meeting. • The 09/20/18 Resident Council meeting minutes indicated there were outstanding dietary concerns from the August 2018 meeting; the response to the outstanding concerns read, “…apologies for kitchen errors, will continue to work on improving food service.” New food-related concerns documented in the meeting minutes included, “Toast not being toasted,” and “Veteran receiving cold oatmeal.” The response to the concerns indicated toast became “soggy under food domes,” and that residents could request oatmeal be reheated in a microwave in the neighborhood. The meeting minutes indicated eight residents from [LOCATION] attended the meeting. • The 10/18/18 Resident Council meeting minutes indicated outstanding dietary concerns included, “Toast not being toasted,” and “Veteran receiving cold oatmeal and soup.” The minutes did not include an approach to resolve the resident’s concerns. The meeting minutes indicated nine residents from [LOCATION] attended the meeting. • The 11/15/18 Resident Council meeting minutes addressed dietary concerns and stated, “Residents requesting a new food vendor - Residents stated food is not

satisfactory…." The response to the concern stated, "Vendor cannot change from…as is food supplier for all VA hospitals." The minutes did not address an alternative to replacing the food vendor (e.g., purchasing different food items, review of food preparation for possible concerns). The meeting minutes indicated eleven residents from the [LOCATION] neighborhood attended the meeting.

- The 12/20/18 Resident Council meeting minutes addressed dietary concerns and stated, "Residents requesting a new food vendor as food not satisfactory." The response to the food vendor concerns stated, "Per Nutrition, food vendor cannot change from….[vendor] is food supplier for all VA Hospitals**No update!** [emphasis not added]" The minutes did not address an alternative to replacing the food vendor. The meeting minutes indicated six residents from the [LOATION] neighborhood attended.
- The 01/17/19 Resident Council meeting minutes addressed dietary concerns and stated, "Fresh food items are coming in on with spoiled [coming in spoiled]." The minutes addressed another concern as, "Residents report that they recently have been receiving care later in the afternoon;" according to the minutes, the neighborhood nurse manager was to follow up on the concern. The meeting minutes indicated ten residents from the [LOCATION] neighborhood attended the meeting.
- The 02/21/19 Resident Council meeting minutes regarding dietary concerns stated, "No change. Veteran reports still reviving [receiving] spoiled fresh foods such as salads," and "Dirty and missing utensils. Veteran report missing and dirty (power [powder] residue) utensils." The response to the concern stated, "…to follow up with kitchen line staff." The meeting minutes indicated nine residents from the [LOCATION] attended the meeting.
- The 03/21/19 Resident Council meeting minutes stated, Veteran complained of "missing items from tray: Veteran reports an increase in missing items from try [tray]. Dirty & missing utensils." The response to the concerns indicated, "To have extra try [tray] sent with tray that have [has] extra utensils, cups, and plates, condiments (honey) on it that can be used for each meal." The action to address items missing from meal trays indicated, "Intern usually monitors trays. Due [to] a change in the semester, Interns are not available at this time. Hope to have new interns assigned to this duty soon." The minutes did not indicate whether concerns identified during the 02/21/19 meeting were resolved. The meeting minutes indicated eight residents from the [LOCATION] neighborhood attended the meeting.
- The 04/18/19 Resident Council meeting minutes stated, "Dirty & missing utensils: Veteran report missing adaptive utensils." "Veteran reports hot water not hot enough." Suggestion: "Veteran requests microwave safe cups so residents can heat water in microwave as needed." The action to address the missing adaptive equipment read, "…reports issues with receiving adaptive equipment back after issued with trays, resulting in insufficient equipment. Will continue to order more equipment to meet the needs." In response to the request for microwave safe cups, the minutes indicated staff would look into what supplies could be ordered. The meeting minutes indicated two residents from the [LOCATION] neighborhood attended the meeting.
- The 05/16/19 Resident Council meeting minutes stated, "Lunch time hours: Nursing concerned that Veterans are requesting feeding [meaning assistance] within the lunch hour and after the lunch hour which causes nursing staff to miss lunch and be delayed in getting residents back to bed." The action (to address the concern) indicated that residents were reminded that "lunch hour times are 11:45 a.m. to 1:00 p.m. Residents are encouraged to eat during that time." "Residents concerned that staff are not attentive to residents needing assistance during meals." Action: "Residents reminded to speak up if they need help and direct their care. Nurse manager to observe upcoming meals and see interactions of staff and residents." The minutes did not indicate whether concerns identified during the 04/18/19 meeting were resolved. The minutes indicated ten residents from [LOCATION] attended the meeting.
- The 06/20/19 Resident Council meeting minutes stated, "Residents report that they frequently receive menu items that they did not order or they are missing items that they did order." Dietary to follow up. "Meal time hours: Veterans concerned that some of the nursing staff is being pulled away from the dining room area to assist Veterans who are eating in their rooms or requested [requesting] to be transferred to bed or take a shower/bath during dinner time around 4:30 p.m. Less staff available to help Veterans in the dining room." The action items listed to address the concerns stated, "Veterans are encouraged to eat in the dining room if they are out of bed and sitting in chair and to schedule bed transfers or showers/baths outside of meal times." "Reminder that lunch hour times are 11:45a [a.m.] - 1:00p [p.m.] and dinner hour times are from 4:45pm - 6pm." The minutes indicated ten residents from the [LOCATION] neighborhood attended the meeting.
- The 07/18/19 meeting minutes did not address concerns with meals or the food; or with staff availability during meals. The minutes indicated five residents attended the meeting.
- In summary, during the survey, residents indicated concerns (grievances) shared with staff were ongoing and not addressed by staff. Resident Council meeting minutes

confirmed ongoing concerns that were not resolved from month to month.

[LOCATION]
Resident #206

- Resident #206's record indicated he was admitted to the CLC on [DATE]; the resident had an approximate 70-pound weight loss in the past year (prior to admission). The resident's comprehensive Minimum Data Set (MDS) dated 06/24/19 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 suggesting intact cognition. The MDS indicated the resident was independent with all activities of daily living (ADLs).
- On 08/07/19, Resident #206 approached a surveyor and stated, "Every day there is something wrong with my meal tray. I get the last tray delivered [in the neighborhood] and if they [food and nutrition services] run out of something I don't get it. The orders are never gotten right. When I ask the dining room staff for help they get mad when you ask for something." The resident also said, "Tonight I didn't get a dessert. I've complained but nothing is done."

Resident #202

- Resident #202's record indicated the resident was admitted to the CLC on [DATE]. The resident's most current quarterly MDS dated 05/08/19 indicated the resident had a BIMS score of 15 suggesting intact cognition. A nutrition note dated 06/28/19 stated, "He occasionally orders food from outside restaurants." The note did not address why the resident ordered from restaurants or address the resident's request for more food choices.
- During an interview on 08/06/19 at 2:00 p.m., the resident stated, "I would like to see more food choices. The menu is the same every three weeks and there is a repetition of entrees like turkey or chicken. I complained but nothing is going to change. If I don't like what they offer, I call and order meals from local restaurants and they deliver."
- During an interview on 08/08/19 at 1:00 p.m., the "food service supervisor" indicated the menu rotated every three weeks and there were no plans to make changes to the menu cycle.

[LOCATION]
Resident Council Minutes

- Resident Council meeting minutes were reviewed for the [LOCATION] neighborhood. The 12/20/18 Resident Council meeting minutes stated, "Slow call light [response] time ongoing issue since August 2018 to current." "Multiple Veterans voiced frustration with Wi-Fi [wireless internet] connection and having difficulties connecting their cell phones, tablets and computer to the Wi-Fi."
- The 01/15/19 Resident Council meeting minutes stated, "Slow call light [response time]: multiple residents stated this is still an issue specially during the night shift." "Multiple residents have spoken to the nurse manager, but issue still continues." "Multiple Veterans voiced frustration with room Wi-Fi connection and having difficulties connecting their cell phones, tablets, and computers to the Wi-Fi" "Issues with Veterans meal trays: Reoccurring issue with Veterans food trays. Veterans stated that what they write on their food ticket is not on their food tray." The minutes indicated five residents attended the meeting.
- The 02/19/19, 03/19/19, 04/17/19 and 05/21/19 Resident Council meeting minutes stated, "Slow call light [response] time: Multiple Veterans stated this is still an issue specially [especially]during the night shift. Veterans gave examples of needing to ask for help more than once and having long wait times. Multiple veterans have spoken to their nurse managers but issue still continues. Veterans were reminded to let staff know about slow call light [response] time and that staff is supposed to be documenting when Veterans bring about this concern." The 02/19/19 minutes indicated four residents attended the meeting. The 03/19/19 Resident Council meeting minutes indicated twelve residents attended the meeting and the 04/17/19 meeting minutes indicated five residents attended the meeting. The 05/21/19 meeting minutes indicated five residents attended the meeting. The 05/21/19 minutes also read, "Upstairs printer does not work for Veteran's to print."
- The 06/18/19 meeting minutes stated, "Ongoing unresolved issues/suggestions: Slow call light [response] time: Multiple Veterans stated this is still an issue specially during the night shift. Veterans gave examples of needing to ask for help more than once and having long wait times. Multiple veterans have spoken to their nurse managers but issue still continues. Veterans were reminded to let staff know about slow call light time and that staff is supposed to be documenting when Veterans bring about this concern so that concerns can be tracked which may resolve this issue based on documentation. Veterans requesting at least 10-15 minutes wait time. They suggested for staff to look out for one another and assist patients if available to do so instead of going to find the assigned nurse/aide to assist the resident." The minutes stated, "Upstairs printer does not work for Veteran's to print." According to the minutes, five residents attended the

meeting. No minutes related to the July 2019 meeting were provided by staff.
- At 1:30 p.m. on 08/08/19, during a meeting with food and nutrition services staff, nursing staff, and providers for [LOCATION]; staff were informed about ongoing concerns addressed in Resident Council meeting minutes from [LOCATION] (in addition to those for [LOCATION]).
- In summary, [LOCATION] Resident Council meeting minutes indicated ongoing concerns that were not resolved from month to month. Residents indicated they have declined to attend further Resident Council meetings since issues are not resolved.

F242

483.15(b) *Self-Determination and Participation. The resident has the right to (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; (2) Interact with members of the community both inside and outside the facility; and (3) Make choices about aspects of his or her life in the facility that are significant to the resident.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure residents had the right to make choices about aspects of life in the CLC that were significant to the resident. Findings include:

[LOCATION]
Resident #302

- Resident #302 was admitted to the CLC on [DATE]. According to the annual provider exam note dated 07/24/19, Resident #302 had a diagnosis of quadriplegia.
- The resident's comprehensive MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 suggesting intact cognition. The MDS indicated Resident #302 required total assistance with transfers, dressing, toileting, personal hygiene, and bathing; and extensive assistance with bed mobility. The MDS indicated Resident #302 had limited range of motion in all four extremities, used a wheelchair, and was not ambulatory. The MDS did not indicate the resident experienced behavioral symptoms of potential distress.
- A 07/09/19 kinesiotherapy note stated, "Pulled therapist aside prior to therapy. Patient stated at this time he would not like to continue therapy. Therapist asked patient why, for further understanding of decision. Patient stated that he is not always able to get up for therapy at the appropriate time to be able to come down to SCI [spinal cord injury] gym."
- A 08/05/19 psychology note indicated the resident described his mood as "mad and frustrated." The note stated, "Veteran voiced frustration related to his inability to get up or transfer to his wheelchair at his specific preferred time 1 pm [1:00 p.m.]." The resident indicated that this was a "new rule" and that "residents cannot get up between 12 [12:00 p.m.] - 2 pm." The note stated that Resident #302 reported he talked with the nurse manager and felt he did not receive a "direct answer." An addendum was added to the note on 08/06/19 that indicated the psychologist talked with the nurse manager and the nurse manager said, "Residents reported that there were not enough staff available to assist with lunch. As a result, it was agreed that no resident would be able to get up [out of bed] between the hours of 12:00 p.m. and 2:00 p.m. unless there was a medical necessity, including a scheduled appointment."
- On 08/07/19 at 9:30 a.m., the nurse manager of [LOCATION] stated residents were not "allowed" to get up (out of bed) between 12:00 to 2:00 p.m. daily and indicated that she talked with Resident #302 about getting up at different times than his requested time of 1:00 p.m. and Resident #302 refused the other times offered. The nurse manager indicated that the 12:00 p.m. to 2:00 p.m. time frame when residents could not get out of bed (unless independent) was initiated by staff to allow staff time to assist residents with dining. The nurse manager indicated that Resident #302 was "Not happy about it [not being permitted to get out of bed at 1:00 p.m.]." The nurse manager added the resident did not have "orders" to be assisted out of bed at specific times.
- Resident #302 indicated wanting to get out of bed at 1:00 p.m., but nursing staff would not "allow" Resident #302 or other residents to get up during these times unless a resident had an appointment. The resident indicated he had an "open area" and the resident felt getting out of bed at 1:00 p.m. would assist in the healing process.
- The resident's plan of care dated 02/06/19 addressed behavioral symptoms of potential distress and depression. An approach dated 08/01/19 was added by the nurse manager and stated, "Resident is upset" and "demanding" to get up at 1:00 p.m. The approach stated, "Will talk to him." Another approach added by the nurse manager on 08/02/19 indicated, "Had a long conversation [with the resident]; offered multiple different times [for the resident to be assisted out of bed], still not happy."
- In summary, Resident #302 requested kinesiotherapy be discontinued; the kinesiotherapist documented the request was made because the resident "is not always able to get up for therapy at the appropriate time to be able to come down to SCI [spinal cord injury] gym." The resident indicated he requested staff assist him out of bed at 1:00 p.m.; however, residents were not "allowed" to get out of bed between 12:00 p.m. and 2:00 p.m., as confirmed by the nurse manager. The CLC did not ensure the resident's right to make choices about aspects of life in the CLC that were significant to the resident.

[LOCATION]
Resident #102

- On 08/06/19 at 10:00 a.m., a nurse manager (NM) indicated that meals were served in the dining room "between 6:30 a.m. and 7:00 a.m., 11:30 a.m. and 12:00 p.m., and 4:30 p.m. and 5:00 p.m."
- On 08/06/19 at 2:20 p.m., Resident #102 stated he ate meals in the dining room but that his meal tray was routinely dropped off in his room while he waited for the meal to be delivered in the dining room. The resident stated he expressed his concerns to the nursing assistant who provided the resident's care, "but it doesn't matter, the trays are always dropped off somewhere else. I kept track and in the last month my tray was left in my room 14 times."

Additional Information

- On 08/07/19 at 7:35 a.m., four residents were observed sitting in the dining room. Resident #102 had a meal tray in front of him while the other three residents did not. One of the three residents stated, "This happens every day; [meal] trays are dropped off in my room rather than in the dining room." The resident was observed to exit the dining room in his wheelchair and return five minutes later holding the meal tray on his lap with one hand while propelling the wheelchair with the other. The resident's meal ticket indicated the resident ate in the dining room. Another one of the three residents exited the dining room in his wheelchair and asked a nursing assistant to help find his meal tray. The nursing assistant returned to the dining room several minutes later with the tray stating, "It was left in your room."
- On 08/07/19 at 7:55 a.m., the "food service supervisor" was interviewed and indicated that food and nutrition service staff delivered meals from a food cart and if a resident was not in the resident's room when the breakfast trays were delivered, "the tray is left in their room."

F248

483.15(f)(1) *Activities. The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.*

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not provide an ongoing program of activities designed to meet the physical, mental and psychosocial wellbeing of each resident. Findings include:

Recreational Therapy Calendar

- Review of the recreational therapy activity calendar included one to three activities a day. For example, on 08/06/19 at 11:00 a.m., technical education was to be provided to teach residents how to use smart phones; on 08/06/19 at 10:00 a.m., five residents were observed participating in the tech group. At 2:00 p.m., a relaxation and meditation activity was to be offered and at 7:00 p.m. bingo was to be provided. On 08/07/19, a 2:00 p.m. trip to the canteen was offered; according to recreational therapy staff, only one resident participated in the event. At 7:00 p.m. on 08/07/19, a Johnny Carson show was to be provided for viewing. On 08/08/19, current events were to be offered at 11:00 a.m. and seated yoga for beginners was to be available at 2:00 p.m.

Resident #106, [LOCATION]

- Resident #106 was admitted to the CLC on [DATE] with diagnoses including non-Alzheimer's dementia and posttraumatic stress disorder (PTSD). The resident was described by the nurse manager during the initial tour on 08/06/19 at 10:00 a.m. as "alert and oriented x 3 [to person, place and time];" the nurse manager indicated the resident had temporarily moved to [LOCATION] around [DATE] while the heating, ventilation and air conditioning system was being replaced in [LOCATION]. The annual history and physical dated 06/23/19 indicated the resident had a depression score of 9 and the resident "often gets bored and feels like his life is empty."
- According to Resident #106's quarterly MDS dated 06/15/19, the resident was usually understood, usually understood others, had a Brief Interview for Mental Status (BIMS) score of 14 suggesting intact cognition, and did not experience behavioral symptoms of potential distress.
- An activity consult note dated 04/01/19 stated, "Preadmission hobbies/interests and past recreational activities: outings, Bingo, music, being outdoors, watching TV, gardening (past). Current: pet therapy, family/social visits, playing rummy cube, watching TV, reading newspapers, chaplain visits…."
- The care plan dated 05/16/19 indicated, "Cognitive loss/dementia: recreational therapy to f/u [follow-up] with Vet [Veteran] for leisure activities. Encourage use of games and puzzles as appropriate. Talk about current events….Activities: Need leisure participation to retain interests. Will increase participation in 1-3 new and familiar leisure activities per week. Please escort and verbal reminders if available and praise willingness to try new activity." The care plan did not address the depression score of 9 or indicate the

resident “often gets bored and feels like his life is empty.” The care plan did not address how the temporary relocation to [LOCATION] may have impacted the resident such as the resident’s activity participation.

- According to the resident’s progress notes, the resident attended bingo and his own birthday party on 07/17/19, bingo on 07/22/19 and 07/26/19, and a discussion group called, “Fact or Fiction” on 08/07/19. The notes did not indicate the resident participated in pet visits on 07/17/19; pet visits were listed on the resident’s plan of care as a current interest.
- On 08/06/19 at approximately 2:00 p.m., Resident #106 approached a surveyor and quality management staff and asked about the purpose of the survey. The resident stated, “I have nothing to do here. All I do is play a game twice a week, roll my wheelchair around and watch TV. My son comes and visits when he can but that is about 10:00 p.m. I don’t like my roommate and I don’t talk to him. There is nothing for me to do. I’m just waiting to die. All the people here are waiting to die.”
- On 08/07/19 at 10:00 a.m., Resident #106 was observed asleep in his room; the room was darkened, and the resident was behind a partially closed privacy curtain, with his wheelchair against the wall and his feet on the bed. At approximately 2:00 p.m., the resident was in the same position but awakened when a surveyor knocked on the door to the resident’s room. The resident said, “I am so lonely here. There is nothing for me to do. I play a game twice a week. I like to go outside but can only go out when my son visits. I am not very comfortable here and do not like my roommate. I wish I had something to do.” The resident’s room was noted to be void of any personal items or recreational therapy activities.
- On 08/07/19 at 2:10 p.m., the recreational therapy assistant said today’s activities included “a canteen trip at 2:00 p.m., and a 7:00 p.m. music activity.” When asked about the canteen trip, the assistant stated that only one resident was escorted to the canteen at 2:00 p.m., although several had signed up for the activity. The recreational therapy assistant did not indicate whether Resident #106 had been invited or signed up to go to the canteen. The recreational therapy assistant said that (activity) groups were scheduled at 11:00 a.m., and 2:00 p.m. and if residents did not attend groups they received one-to-one (1:1) visits. The two recreational therapists (RTs) were interviewed on 08/07/19 at 4:30 p.m. and verified that all 1:1 visits and group participation in activities was documented in resident progress notes. The RTs said they had group activities scheduled at 11:00 a.m. and 2:00 p.m. so it would be easy for residents to remember the times. The RTs indicated that nursing staff did not provide recreational or leisure activities for residents.
- On 08/07/19 at 4:15 p.m., Resident #106 stated, “There is nothing in this place [CLC] I can do. Son visits at 10:00 p.m., then I go to bed. I’m stranded here. The only activity I had today was walking about with my walker for half an hour except going to breakfast and lunch. If this place had activities, I would go. I feel that dying is the only thing I have left to do.”
- On 08/08/19 at 10:20 a.m., the charge nurse in [LOCATION] said, “I have never heard the resident say he was waiting to die and I know he attends activities.” On 08/08/19 at 10:55 a.m., Resident #106’s medical providers were interviewed and indicated they had not heard the resident make statements about dying. One of the medical providers said the resident had been receiving an antidepressant and a gradual dose reduction was completed resulting in elimination of the antidepressant medication. The providers said the resident attended activities when they were offered to the resident.
- In summary, Resident #106 was not observed participating in an activity on 08/06/19 and 08/07/19. On both 08/06/19 and 08/07/19, the resident indicated there was “nothing to do” and that he felt like dying. The annual history and physical dated 06/23/19 indicated the resident had a depression score of 9 and the resident “often gets bored and feels like his life is empty.” According to an activity consult note dated 04/01/19 the resident’s preadmission hobbies/interests and past recreational activities included “outings, Bingo, music, being outdoors, watching TV, gardening (past). Current: pet therapy, family/social visits, playing rummy cube, watching TV, reading newspapers, chaplain visits….” According to the resident’s progress notes, the resident attended bingo and his own birthday party on 07/17/19, bingo on 07/22/19 and 07/26/19, and a discussion group called, “Fact or Fiction” on 08/07/19. The notes did not indicate the resident participated in pet visits that occurred on 07/17/19 or in other activities between 07/17/19 and 08/07/19. The notes did not indicate the resident increased “…participation in 1-3 new and familiar leisure activities per week,” according to the plan of care. The CLC did not ensure an ongoing program of activities to meet the resident’s needs.

<u>Resident #204, [LOCATION]</u>

- According to Resident #204’s record, the resident was admitted to the CLC on [DATE] with diagnoses including blindness; the resident had a fall at home that resulted in surgical repair of a fractured hip.
- Resident #204’s most recent quarterly MDS dated 06/25/19 indicated the resident had a

BIMS score of 3 suggesting severely impaired cognition. The 06/25/19 MDS indicated the resident required limited assistance with transfers and locomotion on the unit (in the neighborhood); the resident was totally dependent on staff for locomotion off the neighborhood and did not walk. The MDS identified activity preferences that were very important to the resident including being around animals such as pets. Activities that were somewhat important included listening to music and doing things with groups of people, going outside to get fresh air when the weather was good and participating in religious services.

- A recreational therapy assessment note dated 10/19/18 stated, “Pre-admission leisure lifestyle: passive. Hobbies, interests and recreation activities: Enjoys listening to “soft music” and conversing. Comments: Therapist interviewed Veteran at bedside this afternoon. Presented as alert pleasant and cooperative throughout the leisure assessment. Able to answer all questions directed to him yet unable to remember date, place or times. States he ‘loves dogs’ and used to have five or six cats and dogs. Enjoys going outside when the weather is nice and was a big hunter and fisherman with this older brother…many years ago. I played poker and baseball. Reports his vision is bad due to the war….often went dancing. Therapist encouraged Veteran to let nursing staff know if he chooses to participate in recreation activities. Therapist will escort Veteran to activities of his choice. No problems noted throughout the encounter, therapist will continue to follow as needed.” Activity needs were identified as, “Monthly calendar, 1:1 [one-to-one] assistance, reminders, bedside activities, encouragement, escort.” Ways to enhance the resident’s activity and recreational skills included, “Audiovisual material, Escort to activities, Individual treatment, Sensory stimulation activities, Access to activities of choice.”
- Resident #204’s care plan dated 10/19/18 addressed activities and indicated the resident’s cognition was poor related to dementia and the resident was at risk for decreased activity, quality of life and isolation. The goal for the resident was to engage in a recreational activity twice a week. The care plan approach stated, “Recreation staff to engage Veteran in conversation, pet therapy. Encourage and escort Vet [Veteran] to activity of his choice.”
- On 12/08/18, a recreational therapy note stated “Individual Pet Therapy Visit, 15 minutes. Veteran agreed to visit with the dog handlers along with Otto, Desi and Tico the therapy dogs. Veteran fully participated, engaging well with therapy dogs, volunteers and staff. Presented as alert, pleasant and cooperative throughout services.”
- A recreational therapy note dated 12/18/18 read, “Diversional activities, Flower Distribution. 60 minutes. Random Acts of Flowers. Patient response to program-Appreciative for flowers.” There were no recreational therapy notes provided between 12/18/18 and 05/01/19.
- A recreational therapy note dated 05/01/19 stated, “90 minutes. Attended full duration of group. Enthusiastic and interested. Level of mobility to attend activities: Independent via manual wheelchair. Attendance and participation will be monitored on an ongoing basis.”
- A recreational therapy note dated 05/22/19 stated, “Kare-9 Military Ministry comfort dog visit…5-15 minutes at bedside. Attentive during entire group. Attended full duration of group. Enthusiastic and interested. Good comprehension.” There were no recreational therapy notes provided between 05/22/19 and 07/04/19.
- The most recent recreational therapy note dated 07/04/19 stated, “Fourth of July Trivia and Sing-a-long. 60 minutes. Response: Attentive during entire group. Attended full group. Enthusiastic and interested. Good comprehension.”
- On 08/06/19 at 2:30 p.m., Resident #204 was interviewed in his room. The resident’s room had few personal items and no recreational therapy items including bedside activities or equipment for playing music. The resident had a television which the resident said he could hear but not see related to blindness; music was not heard playing on the television. The resident was unable to provide information related to his daily activities due to the resident’s cognitive status; the resident did not indicate whether he would like to participate in activities.
- On 08/06/19 at 5:20 p.m., Resident #204 was observed sitting in his wheelchair in the main dining room; the resident was alone and asleep at a table. The television was on and broadcasting the news. The resident exhibited no interest in the television.
- On 08/07/19 at 8:00 a.m., Resident #204 was observed sitting in his wheelchair in the main dining room; the resident was drinking beverages and eating breakfast without assistance. The television was on and the news was broadcasting. On 08/07/19 at 4:35 p.m., Resident #204 was observed alone and asleep while sitting in his wheelchair in the main dining room in front of the TV. At 5:06 p.m., a staff member approached the resident, woke him and asked if he wanted to go to a table for the meal. The resident was pushed in his wheelchair to a table and fell asleep while waiting for the meal. At 5:30 p.m. Resident #204 was wakened and was served the meal.
- In summary, Resident #204 was not observed participating in an activity on 08/06/19 and 08/07/19. According to the recreational therapy assistant assessment dated 10/19/18, the resident enjoyed listening to soft music, conversing and loved dogs. The

resident also enjoyed going outside, used to play poker and baseball, and often went dancing. The resident's care plan included a goal for the resident to engage in a recreational activity twice a week. Recreational therapy notes (12/08/18, 12/18/18, 05/01/19, 05/22/19 and 07/04/19) were provided by staff and indicated the resident "fully participated," was "enthusiastic and interested," and was "alert, pleasant and cooperative throughout services." The notes did not indicate the resident participated in or was invited and declined to participate in activities twice a week. The CLC did not ensure an ongoing program of activities to meet the resident's needs.

F309

483.25 *Quality of Care. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by §483.25(a)-(m).*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure that each resident received necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Findings include:

Resident #105, [LOCATION]

- Resident #105 was admitted to the CLC on [DATE] with a diagnosis of dementia and was receiving hospice care. The quarterly MDS dated 06/12/19, indicated the resident was rarely understood and rarely understood others; the resident had severely impaired cognitive skills for daily decision making based on staff assessment. According to the MDS, the resident required total assistance with activities of daily living (ADLs) including bed mobility.
- On 08/06/19 at 1:30 p.m., Resident #105 was observed semi-reclined in a Broda chair in the hallway across from the nursing station. The resident had slid down in the chair and the resident's legs and feet were dangling off the leg rests of the chair and were approximately four to five inches above the floor. The resident's thighs were supported by the leg rests, but his lower legs were dangling in a dependent position placing pressure on the back of the resident's thighs. According to the resident's spouse, she visited frequently and the resident was usually in the same position. On 08/06/19 at 1:35 p.m., the footrest from the Broda chair was observed in the resident's room, folded up, and on the floor next to the nightstand.
- On 08/06/19 at 2:20 p.m., Resident #105 was observed in the same position, with both legs and feet dangling four to five inches from the floor. The resident's thighs were supported by the leg rests, but his lower legs were dangling in a dependent position placing pressure on the back of the resident's thighs.
- On 08/07/19 at 7:40 a.m., 8:10 a.m., and 10:00 a.m., Resident #105 was observed sitting in the Broda chair across from the nursing station with his feet dangling three to four inches from the floor. The resident's thighs were supported by the leg rests, but his lower legs were dangling in a dependent position placing pressure on the back of the thighs. At 1:40 p.m., the resident was observed in the same position; the resident was semi-reclined in the Broda chair. When asked if the resident was going to be assisted back to bed, the RN stated, "He stays up all day because if they [staff] lay him down and he's not tired then he will try and get up. He's safer this way."
- On 08/07/19 at 9:40 a.m., the nurse manager was interviewed regarding observations of the resident's positioning in the Broda chair on 08/06/19 and 08/07/19. In response to the resident's legs and feet dangling from the Broda chair's leg rests, the NM stated, "At least his heels are off loaded."

F312

483.25(a)(3) *A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure a resident who was unable to carry out activities of daily living received necessary services to maintain good grooming and personal hygiene. Finding include:

Resident #105, [LOCATION]

- Resident #105 was admitted to the CLC on [DATE] with a diagnosis of dementia and was receiving hospice care. The quarterly MDS dated 06/12/19 indicated the resident was rarely understood and rarely understood others; the resident had severely impaired cognitive skills for daily decision making based on staff assessment. According to the MDS, the resident required total assistance with activities of daily living (ADLs) including personal hygiene and did not reject care.
- The care plan dated 08/09/17 stated, "Provide showers on Tues [Tuesday], and Fri. [Friday] mornings. Nail care as needed." The care plan did not indicate that the resident rejected care.
- On 08/06/19 at 1:30 p.m., the resident was observed semi-reclined in a Broda chair in the hallway across from the nursing station. The resident was observed to have his hands in a clenched position (fingers curled into the palms) with long and jagged thumb

nails that extended approximately 1/4 inch beyond the end of the thumbs. The resident's spouse was interviewed and stated, "He can open his hands but his fingernails are long and dig in. He keeps them closed up."
- On 08/06/19 at 4:20 p.m., the resident was observed lying in bed. The resident was observed with long and jagged fingernails on both hands, some extending 1/4 inch or more past the end of the fingers.
- On 08/07/19 at 8:10 a.m., the resident was observed sitting in a Broda chair across from the nursing station. The resident was observed with long and jagged fingernails on both hands. The fingernails extended approximately 1/4 inch beyond the end of the resident's fingers. Following the observation, the surveyor discussed the resident's fingernails with the nurse manager.
- On 08/07/19 at 1:40 p.m., an RN assisted the resident with opening the resident's hands. The resident's nails had been trimmed and the RN said, "He had a shower this morning [following the 8:10 observation] and his nails were cut." The RN stated the resident did not resist care and was "easily redirectable."

F314

483.25(c) *Pressure Sores. Based on the comprehensive Assessment of a resident, the facility must ensure that (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure pressure ulcer prevention interventions were provided for a resident identified at high risk for pressure ulcer development. Finding include:

The CLC policy titled, "Pressure Injury Prevention and Management," and dated August 30, 2016, was provided by the quality management representative on 08/07/19 at 10:30 a.m. According to the policy, pressure injury prevention measures included, "Elevate the heels off the bed surface…consult for individualized selection of reevaluation of seating support surfaces and associated equipment for posture and pressure redistribution."

Resident #105, [LOCATION]

- Resident #105 was admitted to the CLC on [DATE] with a diagnosis of dementia and was receiving hospice care. The quarterly MDS dated 06/12/19, indicated the resident was rarely understood and rarely understood others; the resident had severely impaired cognitive skills for daily decision making based on staff assessment. According to the MDS, the resident required total assistance with activities of daily living (ADLs) including bed mobility. The MDS indicated the resident was at risk for development of pressure ulcers and had no pressure ulcers; skin and ulcer treatments coded on the MDS included pressure reducing devices for a chair and bed, a turning and repositioning program, nutrition or hydration interventions, and application of dressings to the feet.
- The care plan dated 08/09/18 indicated the resident was at risk for pressure ulcers. Approaches included a "low air loss mattress," "turn and reposition q [every] 2 hours," "Prevalon boots or keep heels off of mattress by elevating them on pillows," and "pressure reducing seat cushion[,] shift weight every 2 hours."
- A provider order dated 12/18/18 read, "Please change turn patient every 2 hours NOW to please turn pt [patient] every 2-3 hours when in bed and offload heels in bed."
- The most current nursing skin assessment dated 06/17/19 documented a Braden Scale for Predicting Pressure Ulcer Risk score of 12 suggesting high risk. Approaches for pressure ulcer prevention identified in the skin assessment included: "Time in chair or wheelchair limited to less than or equal to 1 hour" and "heels offloaded [elevated] off the bed surface."
- The most recent nursing quarterly note dated 06/17/19 indicated, "Skin - redness noted to heels but blanchable."
- On 08/06/19 at 4:20 p.m., Resident #105 was observed in bed and appeared to be sleeping. The resident was positioned with a pillow under his knees and both heels resting directly on the mattress; the resident was wearing socks on both feet. No Prevalon boots were visible in the resident's room. On 08/06/19 between 5:30 p.m. and 5:55 p.m. the resident moved in bed causing the bed alarm to sound. An RN and a nursing assistant (NA) entered the room several times to respond to the alarm and repositioned the resident in bed. Each time the resident was repositioned, the pillow was placed under the resident's knees leaving both heels resting directly on the mattress.
- On 08/07/19 at 9:40 p.m., the nurse manager was interviewed regarding the observation on 08/06/19 of the resident's heels not being off loaded while the resident was in bed. The NM indicated staff tried the Prevalon® boots and the resident did not want to wear the boots. There was no documentation provided to confirm the resident did not want to wear the Prevalon boots and the care plan did not indicate the resident did not want to wear the boots.

F323

483.25(h)(2) *The facility must ensure that: Each resident receives adequate supervision and assistance devices to prevent accidents.*

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure residents received adequate supervision to prevent accidents. Findings include:

Accident Prevention Related to Falls

The CLC policy titled, "Patient Falls Prevention Program," and dated January 10, 2017, was provided by the quality management (QM) representative on 08/07/19 at 8:40 a.m. According to the policy, "(2) for patients [residents] deemed 'high risk' the nurse will…(e) utilize bed alarm/chair alarms as appropriate….(3) For all patients regardless of fall risk score utilize appropriate interventions with the goal of preventing falls or injury related to falls."

Resident #101, [LOCATION]

- Resident #101 was admitted to the CLC on [DATE] with diagnosis that included non-Alzheimer's dementia and posttraumatic stress disorder (PTSD).
- The quarterly MDS dated 05/14/19 and the comprehensive MDS dated 07/30/19 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14 suggesting intact cognition; the resident understood and was understood by others and did not experience behavioral symptoms. According to the MDS, the resident was independent in bed mobility, required supervision for transfers and required limited assistance with walking in the resident's room. The MDS indicated the resident was not steady but able to stabilize without staff assistance when moving from a seated to a standing position, walking, turning, and moving on and off a toilet; the resident had functional limitations in range of motion in the upper and lower extremities on both sides. The 05/14/19 MDS indicated the resident had one fall with no injury; bed or chair alarms were not used. According to 07/30/19 MDS, the resident had two falls since the previous assessment (one fall without injury and one fall with an injury that was not major); chair alarms were used daily. According to the Care Area Assessment (CAA) summary dated 08/01/19 and completed in conjunction with the 07/30/19 MDS, the resident was at risk for falls due to an unsteady gait, a history of a stroke and the resident had a "tendency to forget limitations. Some dementia. Most falls occur with transfers."
- On 08/06/19 at 10:00 a.m. during the initial tour, the nurse manager (NM) indicated the resident was "Very forgetful and has frequent falls. He had a fall last Saturday [07/27/19] when he transferred from his wheelchair to the toilet. He had a small abrasion on his head and we changed to having an alarm." According to the NM, the resident had room changes on 06/10/19 due to residents from another neighborhood being temporarily relocated to [LOCATION], and on 07/15/19 "per his request due to not caring for his roommate."
- The resident's care plan was updated on 02/13/18, addressed falls and stated, "Morse fall score = 60 high risk for falls." Approaches included ensuring the resident locked his wheelchair for all transfers, providing reminders for restorative therapy, encouraging the resident to wear gripper socks, and nurse rounding to ensure resident needs were met. No new approaches were added to the care plan following falls on 04/08/19, 07/02/19 and 07/27/19.
- Resident #101 had the following falls as determined during record review and staff interview:
    - According to adverse event notes dated 04/08/19 at 11:50 a.m., the resident, "was noted by two staff members independently transferring from the motorized scooter to the wheelchair when he began to slowly fall to the ground on his knees[,] staff was able to assist him to the ground and back into his wheelchair." Interventions identified included bed and chair alarms, reinforcing the need for assisted and supervised transfers, moving the resident closer to the nursing station, "surveillance" every hour, and remaining with the resident during toileting; alarms were used "as a reminder to call for assistance." An alarm was not placed on the motorized scooter so it was not clear as to how an alarm would remind the resident to call for assistance when transferring from the scooter to the wheelchair.
    - According to an adverse event report dated 07/02/19 at 3:02 p.m., the resident informed staff he was experiencing chest pain over the left lower rib area described as "sharp." The resident reported that he "fell this morning in the bathroom (door closed so didn't tell anyone and stated, 'I didn't want to bother them too much') and hit his left chest over [toilet] handle. He was trying to get up of [off] the toilet…."The adverse event report documented, "Complete circumstances behind unwitnessed fall unknown. Suspect mechanical d/t [due to] deconditioning, incorrect size of hospital gown, and unsafe practice of transferring are most likely culprit…." A post fall huddle note dated 07/02/19 indicated the resident's Morse Fall Scale score was 95 suggesting high risk for falls; the post fall note stated, "Pt [patient] unable to recall reason he fell. Pt states he hit his chest on the side of the toilet. Follow up plan: chair alarm, promise to call for assistance." Although the 04/08/19 adverse event note

indicated staff were to remain with the resident during toileting, this intervention was not in place at the time of the 07/02/19 fall. It was not clear how a chair alarm as indicated as an intervention in the post fall huddle note would prevent further falls from the toilet. Approaches were not implemented to address causal and contributing factors.

- According to an adverse event report dated 07/27/19 at 1:08 p.m., the resident stated, “I was going to the bathroom and I got dizzy;” the resident was found “on the floor with his knees leaning forward with his head on the ground.” The note indicated the resident had abrasions on his head and right hand and suspected impact to the head. The Morse Fall Scale score was 100 suggesting high risk for falls. The post fall huddle noted dated 07/27/19 read, “Vet [Resident #101] states he was going to the bathroom and got dizzy. Follow up plan: Chair alarm, will call, bed alarm not on.” Interventions remained the same as identified in the 07/02/19 post fall huddle note except it was suggested that the resident be moved closer to the nursing station. Note that the resident was moved closer to the nursing station following a fall on 04/08/19; room changes that occurred on 06/10/19 and 07/15/19 were also to move the resident in close proximity to the nursing station. Although it was indicated that the bed alarm did not sound when the resident transferred out of bed, there was no investigation conducted to determine why. Approaches were not implemented to address causal and contributing factors.
- According to the nursing summary dated 08/05/19, the resident “had two falls on 7-2 [07/02/19] and 7-27 [07/27/19] suspected head trauma on second fall and sent for CT [computed tomography] of head. No sig [significant] findings/changes noted. Latest Morse fall = 100 fall preventions are in place. Resident was moved to [room number] which is closer to the nurse’s station.” Note the resident had been in this room since 07/15/19, prior to the 07/27/19 fall.

- Resident #101 was interviewed on 08/07/19 at 4:40 p.m. When asked about the resident’s recent fall on 07/27/19, the resident said, “I fell in the bathroom and hit my head. Nothing was broke I just hurt. I’m supposed to call for someone but no one comes. Not sure if they have enough staff. Then I fall and no one comes.” None of the post fall notes indicated the resident was interviewed to determine if he requested assistance/used the call light to ask for help prior to falling.
- The safety risk manager was interviewed on 08/08/19 at 9:45 a.m., and indicated that when she was notified of an adverse event, she completed an assessment of the event. Regarding Resident #101’s 07/02/19 and 07/27/19 falls, the safety risk manager stated, “There were no reports filed and I was not informed of the falls. It was the same nurse involved with both falls and I will be providing education to her.” The safety risk manager indicated that if an assessment had been conducted following the 07/02/19 fall, the 07/27/19 fall may have been avoided.
- In summary, Resident #101 experienced falls on 04/08/19, 07/02/19 and 07/27/19; the 07/27/19 fall resulted in abrasions to the resident’s head and hand. A root cause analysis was not conducted to determine causal and contributing factors and approaches implemented did not address causal and contributing factors. For example, bed and chair alarms were implemented following each fall; however, one fall occurred while the resident was transferring from the scooter to the wheelchair and one fall occurred while transferring from the toilet (and not from the bed or chair). It was noted following the 07/27/19 fall that the bed alarm did not sound when the resident transferred out of the bed; however, no investigation was conducted to determine why. Another approach implemented following a fall was to move the resident closer to the nursing station; however, it was noted that the resident had previously been moved closer to the nursing station prior to the fall. A third approach was to remind the resident of the need for assistance and supervision during transfers. When asked about the resident’s recent fall on 07/27/19, the resident said, “I fell in the bathroom and hit my head….I’m supposed to call for someone but no one comes. Not sure if they have enough staff. Then I fall and no one comes.” None of the post fall notes indicated the resident was interviewed to determine if he requested assistance/used the call light to ask for help prior to falling.

Resident #204, [LOCATION]

- Resident #204 was admitted to the CLC on [DATE] with diagnoses that included bradycardia, blindness, and osteopenia; the resident had a fall at home that resulted in surgical repair of a fractured hip.
- The resident’s comprehensive MDS dated 10/25/18 and most recent quarterly MDS dated 06/25/19 indicated the resident scored a 3 on the BIMS suggesting severely impaired cognition. The 06/25/19 MDS indicated the resident needed limited assistance with transfers and locomotion on the unit (neighborhood); the resident was totally dependent on staff for locomotion off the neighborhood and toilet use; the resident was unable to walk. The 06/25/19 MDS indicated the resident had a fall that occurred in the month prior to admission that resulted in a major injury (hip fracture) and two or more

falls since admission which resulted in no injury.

- The nursing admission assessment dated [DATE] included a Morse Fall Scale score of 80 suggesting high risk for falls; risk factors included a history of falls, a secondary diagnosis of dementia, the use of an ambulatory aid, impaired gait and the resident overestimating or forgetting limitations.
- The resident's care plan dated 10/19/18 indicated the resident scored 80 on the Morse Fall Scale and was at high risk for falls due to impaired mobility, confusion and blindness. Approaches included monthly fall assessments; a yellow, falling star sign posted on the resident's door; nonskid, yellow socks; and hourly surveillance for positioning, pain, placement of possessions, personal hygiene and toileting. The care plan had not been updated since 10/19/18 and did not address the use of bed or chair alarms.
- A provider's order dated 06/21/19 read, "Fall precautions."
- On 08/06/19 at 11:00 a.m. during the initial tour, a charge nurse and nurse manager indicated Resident #204 was "blind" and had several falls since admission to the CLC. It was also reported that prior to admission the resident had a fall at home that resulted in a fractured hip.
- Resident #204 experienced falls on 10/22/18, 11/03/18, 01/02/19, 06/14/19 and 06/21/19. Pertinent documentation included the following:
    - A fall assessment documented on 10/22/18 indicated the resident's Morse Fall Scale score was 80 suggesting high risk. A fall note dated 10/22/18 indicated Resident #204 had an unwitnessed fall on 10/22/18 at 7:00 p.m. in the resident's room. According to the fall note, "He slipped and fell while transferring from toilet to wheelchair….Resident observed on floor in sitting position…." Fall prevention interventions listed in the note included: "Resident education: Orient to surroundings. Purpose and use of call light. Use of non-skid slippers or gripper socks. Request assistance for daily activities (such as getting out of bed, toileting, transfers)….Place patient/resident articles within easy reach, Call light if applicable in easy reach and answered promptly…." The note did not indicate if the resident was asked if he called for assistance prior to attempting to transfer independently; if the wheelchair alarm sounded when the resident transferred to the toilet; or the last time surveillance rounds were conducted prior to the fall. No documentation was provided to support the fall prevention approaches implemented prior to the fall were evaluated to determine effectiveness. A root cause analysis was not conducted with approaches implemented to address causal and contributing factors for the fall.
    - On 11/03/18, the resident's Morse Fall Scale score was 75 suggesting high risk. According to a fall note, Resident #204 had a subsequent fall on 11/03/18; the document read, "Patient fall: at 10:40 a.m. Resident bathroom. Resident statement; 'I needed to use the bathroom, so I went.' Resident observed on the bathroom floor in sitting position. Skin to right arm, scant bleeding. Complains of pain 4/10 [on a scale of 0 to 10, with 10 being the worst pain possible] right leg." The note stated the wheelchair alarm was on when staff entered the bathroom. The plan to prevent additional falls stated, "Reinforce need for assistance/supervised transfers....Complete surveillance rounds every 1 hour....Remain with patient/resident during toileting. Provide bedside toileting devices (urinal, bedside commode.) Injury Prevention…maintain safety. Assist with Mobility: Create "Safe Exit Side" for transfer from bed. Patient/Resident forgets limitations…Re-educate/reminders regarding safety. Observe every one hour…" The fall note did not indicate whether care planned approaches were followed at the time of the resident's fall and the effectiveness of those interventions. The note did not indicate if the resident was asked if he called for assistance prior to attempting to transfer independently or the last time surveillance rounds were conducted prior to the fall. A root cause analysis was not conducted with approaches implemented to address causal and contributing factors for the fall.
    - A nursing note dated 01/02/19 described a fall that occurred at 3:20 a.m. in the resident's room. The note indicated, "Bed alarm on and call light within reach. Pt. [patient] woke-up at 2:00 a.m. and his bed alarm goes off 2x [times] before he fell due to pt. kept on getting up and down [from] the bed. Pt. is with periods of confusion at 3:20 a.m. bed alarm goes off and was seen by staff that pt. get [got] up from the bed tried to push his wheelchair and lost his balance and fell on the floor on his buttocks and shoulder. Noted a small skin tear with bruise on his right elbow." Fall prevention interventions were similar to those identified following the 11/03/19 fall; no new approaches were identified. The notes did not indicate whether care planned approaches were in place at the time of the resident's fall and the effectiveness of those interventions. The notes did not indicate if the resident was asked if he called for assistance prior to attempting to transfer independently or the last time surveillance rounds were conducted prior to the fall. A root cause analysis was not conducted with approaches implemented to

address causal and contributing factors for the fall. It was not clear why staff did not provide more frequent supervision of the resident when the resident had periods of confusion in bed and the bed alarm sounded indicating the resident was moving in bed.

- According to a fall note, Resident #204 had an unwitnessed fall on 06/14/19 at 1:30 p.m. in the resident's room. The resident was "observed lying on the floor on his back. Vet wearing non-skid socks and dermaplast shoes at the time of fall. Vet stated he was attempting to transfer from the bed to his wheelchair when he slipped and fell. Wheelchair noted behind him with wheels locked, floor dry and free [of] clutter. Morse scale – 80 [high risk]…." Fall prevention approaches implemented to prevent additional falls were similar to those implemented on 11/03/18 and included but were not limited to: "Orient to surroundings. Purpose of call light. Non-skid slippers. Request assist…Bed alarm on. Reinforce need for assisted supervised transfers….complete surveillance round every one hour;" no new approaches were implemented. The note did not indicate whether care planned approaches were followed at the time of the resident's fall and the effectiveness of those interventions. The note did not indicate if the resident was asked if he called for assistance prior to attempting to transfer independently; when surveillance rounds were last conducted prior to the fall; or if the bed alarm was sounding when the resident was found on the floor. A root cause analysis was not conducted, and approaches were not implemented to address causal and contributing factors for the fall.
- According to a fall note, the resident's most recent fall occurred on 06/21/19 at 06:35 a.m. in Resident #204's room. The note stated, "Resident could not recall how he was sitting on the floor. Resident observed sitting upright leaning on his bed[,] non-skid socks on [and] dermaplast shoes on. Room was lit[,] floor was dry without clutter[,] wheelchair on resident's right side. Morse score 50." Fall prevention approaches were similar to those identified following the fall on 06/14/19; no new interventions were identified. The note did not indicate whether current care planned approaches were provided at the time of the resident's fall or the effectiveness of those interventions. The note did not indicate if the resident was asked if he called for assistance prior to attempting to transfer independently or when surveillance rounds were conducted prior to the fall. A root cause analysis was not conducted with approaches implemented to address causal and contributing factors for the fall.

- On 08/06/19 at 2:30 p.m., Resident #204 was interviewed in his room. The resident was seated in a wheelchair near the bed. The resident informed the surveyor, "I can't see." The resident's call light was observed on the resident's bed approximately three feet from the resident and not within reach. During the interview, an alarm was beeping in the resident's room. The nurse manager determined the beeping was coming from the resident's chair alarm that was located on the resident's wheelchair. The nurse manager said, "It's beeping and needs new batteries."
- On 08/06/19 at 5:20 p.m., Resident #204 was observed sitting in his wheelchair in the main dining room. Staff were not in the vicinity and the resident was alone and appeared to be asleep at a table. The resident did not have a method to call for assistance if needed.
- On 08/07/19 at 4:30 p.m., Resident #204 was observed sitting in his wheelchair and appeared to be asleep in the main dining room. Staff were not in the vicinity. The resident was unsupervised and without a method to call for assistance if needed. At 5:06 p.m., a staff member approached the resident.
- In summary, Resident #204 was admitted to the CLC on [DATE] and experienced falls on 10/22/18, 11/03/18, 01/02/19, 06/14/19 and 06/21/19. The resident's comprehensive MDS dated 10/25/18 and most recent quarterly MDS dated 06/25/19 indicated the resident scored a 3 on the Brief Interview for Mental Status suggesting severely impaired cognition; the resident was blind. The resident's care plan dated 10/19/18 indicated the resident scored 80 on the Morse Fall Scale and was at high risk for falls due to impaired mobility, confusion and blindness. Approaches included monthly fall assessments; a yellow, falling star sign posted on the resident's door; nonskid, yellow socks; and hourly surveillance for positioning, pain, placement of possessions, personal hygiene and toileting. Following each fall similar approaches were implemented including reminding the resident to use the call light to ask for assistance when transferring. Root cause analysis was not conducted, and approaches were not modified to address causal and contributing factors. Supervision was not provided to prevent accidents. For example, a nursing note dated 01/02/19 indicated, "Bed alarm on and call light within reach. Pt. [patient] woke-up at 2:00 a.m. and his bed alarm goes off 2x [times] before he fell due to pt. kept on getting up and down [from] the bed. Pt. is with periods of confusion at 3:20 a.m. bed alarm goes off and was seen by staff that pt. get [got] up from the bed tried to push his wheelchair and lost his balance and fell on the floor on his buttocks and shoulder. It was not clear why staff did not provide more frequent supervision for the resident when the resident had periods of confusion in bed

and the bed alarm sounded indicating the resident was moving in bed. On 08/06/19 at 2:30 p.m., Resident #204 was interviewed in his room. The resident was seated in a wheelchair near the bed. The resident informed the surveyor, "I can't see." The resident's call light was observed on the resident's bed approximately three feet from the resident and not within reach. On 08/06/19 at 5:20 p.m. and 08/07/19 at 4:30 p.m., Resident #204 was observed sitting in his wheelchair in the main dining room. Staff were not in the vicinity and the resident was alone and appeared to be asleep at a table. The resident did not have a method to call for assistance if needed.

Resident #104, [LOCATION]

- Resident #104 was admitted to the CLC on [DATE] with diagnoses that included "morbid obesity" and a right ankle fracture. According to the history and physical dated [DATE], the resident was unable to bear weight on the right extremity and was on fall precautions that included a low bed and floor mats; the resident was described as "being capable of making decisions."
- The resident's admission 5-day MDS dated [DATE] indicated the resident had a BIMS score of 14 suggesting intact cognition; the resident understood and was understood by others. According to the MDS, the resident was independent with bed mobility and required limited assistance with transfers, dressing and toilet use. The MDS indicated the resident had falls in the past 2 to 6 months with major injury (right ankle fracture).
- Resident #104's current care plan dated 07/11/19 included the following statement, "Potential for falls r/t [related to] deconditioning. Hx [history] of right ankle fracture." Approaches included: "Educate vet [Veteran] on fall precaution measures. Keep w/c [wheelchair] locked before transferring, Vet is NWB [non-weight bearing] on right leg. Vet is able to scoot into his w/c with 1 assist [one staff member for assistance] (vet is using a sliding board in therapy and will be given one to use on the ward [neighborhood]). Vet has been instructed not to use the sliding board on the unit unless he is supervised….Use the call light for help."
- According to the nursing admission assessment dated [DATE], the Morse Fall Scale score was 50 suggesting high risk for falls. The admission assessment stated, "He [Resident #104] fell 2x [twice] in the last week of May" which resulted in a right ankle fracture. Fall prevention interventions included completing surveillance rounds every hour, remaining with the resident during toileting, a height adjustable bed, and using alarms (bed and/or chair not specified) as a reminder to call for help.
- An event investigation dated 07/30/19 stated, "Resident found on floor sitting next to his bed in room. He was alert and said he slid off the bed. He did not hit head. He had ROM [range of motion] and no pain. Needed assist[ance] to get back into bed. No harm. Action taken: assisted to safety, reminded to call for assistance. Continue to monitor, hourly rounding, call light within reach, re-educated on calling for assistance. Contributing factors: none." A fall note dated 07/30/19 at 11:55 p.m. indicated, "Resident states he slid off bed onto the floor onto his buttocks. He denies hitting his head." The fall assessment dated 07/31/19 indicated, "He had a fall on 07/30/19 night/early morning. He said he was sitting on the edge of his bed trying to get into his chair to use the bathroom. He said he called for help but could not wait and tried to rush into his chair. The air mattress inflated and he was sort of pushed up and resulted in a fall. He landed on his buttock. No head injuries or LOC [loss of consciousness]. He hit his left elbow slightly against the bed but is able to move it with good range of motion. Has some pain in his elbow (describes as tenderness)." The plan stated, "Encouraged patient to ask for help and wait for help to avoid falls. Nursing and I met with the patient and educated him about the importance of adhering to the transfer board and any other recommendations to avoid adverse events like falls, etc. especially since he is on an anticoagulation [*sic*]." No investigation was conducted to determine how long the resident waited for assistance after calling for help or to determine if the mattress was appropriate in consideration of the mattress inflating and pushing the resident "up" resulting in the fall. Approaches were not implemented to address causal and contributing factors.
- During an interview on 08/06/19 at 1:35 p.m., Resident #104 said he had a fall at home and fractured his ankle and "last week I fell off this bed. I was sitting on the edge of the bed waiting for staff to help me get to the bathroom. I waited as long as I could and was getting ready to go myself, when the bed inflated and deflated and I slipped onto the floor. It pushed me out. My left hip started hurting and they took an x-ray today." The quality management representative indicated on 08/07/19 that the x-rays of the left hip and pelvis were negative.
- The NM was interviewed on 08/07/19 about the resident's report of the mattress pushing him out of bed and onto the floor. The NM said, "Yes, the top of the mattress is so slick. It's the nature of the beast and we use those beds hospital wide. He slid right off. It's a slick top and that's just how they are made."

F353

483.3 *Nursing Services. The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Some

Based on observation, interview and record review, the facility did not have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Findings include:

Resident #302, [LOCATION]

- During an interview at 9:40 a.m. on 08/07/19, Resident #302 stated nursing staff recently informed residents they could no longer “get up [out of bed]” between 12:00 p.m. and 2:00 p.m. An 08/05/19 psychology note stated, “Veteran voiced frustration related to his inability to get up or transfer to his wheelchair at his specific preferred time 1 pm [1:00 p.m.].” An addendum was added to the note on 08/06/19 that indicated the psychologist talked with the nurse manager and the nurse manager said, “Residents reported that there were not enough staff available to assist with lunch. As a result, it was agreed that no resident would be able to get up [out of bed] between the hours of 12:00 p.m. and 2:00 p.m. unless there was a medical necessity, including a scheduled appointment.” (See Self-determination and Participation)

Resident #101, [LOCATION]

- Resident #101 was admitted to the CLC on [DATE] with diagnosis that included non-Alzheimer’s dementia and posttraumatic stress disorder (PTSD). The quarterly MDS dated 05/14/19 and the comprehensive MDS dated 07/30/19 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14 suggesting intact cognition; the resident understood and was understood by others and did not experience behavioral symptoms. Resident #101 experienced falls on 04/08/19, 07/02/19 and 07/27/19. One approach implemented following each fall was to remind the resident of the need for assistance and supervision during transfers. According to a fall note on 07/02/19 at 3:02 p.m., the resident informed staff he was experiencing chest pain over the left lower rib area described as “sharp.” The resident reported that he “fell this morning in the bathroom (door closed so didn’t tell anyone and stated, ‘I didn’t want to bother them too much.’) and hit his left chest over [toilet] handle. He was trying to get up of [off] the toilet….” During the survey, when the resident was asked about the most recent fall on 07/27/19, the resident said, “I fell in the bathroom and hit my head….I’m supposed to call for someone but no one comes. Not sure if they have enough staff. Then I fall and no one comes.” None of the post fall notes indicated the resident was interviewed to determine if he requested assistance or used the call light to ask for help prior to falling. (See Accidents)

Resident #104, [LOCATION]

- Resident #104 was admitted to the CLC on [DATE] with diagnoses that included “morbid obesity” and a right ankle fracture. According to the history and physical dated [DATE], the resident was unable to bear weight on the right extremity and was on fall precautions that included a low bed and floor mats; the resident was described as “being capable of making decisions.” The resident’s admission 5-day MDS dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14 suggesting intact cognition; the resident understood and was understood by others. A fall assessment note dated 07/31/19 indicated, “He had a fall on 07/30/19 night/early morning. He said he was sitting on the edge of his bed trying to get into his chair to use the bathroom. He said he called for help but could not wait and tried to rush into his chair. The air mattress inflated and he was sort of pushed up and resulted in a fall. He landed on his buttock….” No investigation was conducted to determine how long the resident waited for assistance after calling for help or to determine if the mattress was appropriate in consideration of the mattress inflating and pushing the resident “up” resulting in the fall. During an interview on 08/06/19 at 1:35 p.m., Resident #104 said he had a fall at home and fractured his ankle and “last week I fell off this bed. I was sitting on the edge of the bed waiting for staff to help me get to the bathroom. I waited as long as I could and was getting ready to go myself, when the bed inflated and deflated and I slipped onto the floor. It [the bed] pushed me out….”

Additional Information

- Resident Council meeting minutes were reviewed for the [LOCATION] neighborhood. The 12/20/18 Resident Council meeting minutes stated, “Slow call light [response] time ongoing issue since August 2018 to current.” The 01/15/19 Resident Council meeting minutes stated, “Slow call light [response time]: multiple residents stated this is still an issue specially [especially] during the night shift.” “Multiple residents have spoken to the nurse manager, but issue still continues.” The 02/19/19, 03/19/19, 04/17/19 and 05/21/19 Resident Council meeting minutes stated, “Slow call light [response] time: Multiple Veterans stated this is still an issue specially during the night shift. Veterans gave examples of needing to ask for help more than once and having long wait times.

Multiple veterans have spoken to their nurse managers but issue still continues. The 06/18/19 meeting minutes stated, “Ongoing unresolved issues/suggestions: Slow call light [response] time: Multiple Veterans stated this is still an issue specially during the night shift. Veterans gave examples of needing to ask for help more than once and having long wait times. Multiple veterans have spoken to their nurse managers but issue still continues.” (See Prompt Efforts to Resolve Grievances)

F364

483.35(d)(2) *Each resident receives and the facility provides: Food that is palatable, attractive, and at the proper temperature;*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure residents received food that was palatable. Findings include:

[LOCATION]

- During an interview on 08/06/17, a resident residing in the [LOCATION] neighborhood and who wished to remain anonymous stated, “Sometimes they [staff] give me three knives and no fork or spoon for meals and others [other residents] no knife or fork but only a spoon at meals. Sometimes I get coffee but no cream and other times I get the cream but no coffee at meals. The food is bland. Usually the food is cold, but they [nursing staff] will warm it up in the microwave….I used to go to the Resident Council meetings and complained about the meal service, but I quit going because they [staff] never do anything about our complaints.”
- On 08/07/19, another resident residing in the [LOCATION] neighborhood requested to be interviewed and requested anonymity. The resident continually stated, “I don’t want this in my record.” When asked about the food, the resident stated the food served was “slop.”

Additional Information

- The 09/20/18 Resident Council meeting minutes indicated new food-related concerns included, “Toast not being toasted,” and “Veteran receiving cold oatmeal.” The response to the concerns indicated toast became “soggy under food domes,” and that residents could request oatmeal be reheated in a microwave in the neighborhood.
- The 10/18/18 Resident Council meeting minutes indicated outstanding dietary concerns included, “Toast not being toasted,” and “Veteran receiving cold oatmeal and soup.” The minutes did not include an approach to resolve the resident’s concerns.
- The 11/15/18 and 12/20/18 Resident Council meeting minutes addressed dietary concerns and stated, “Residents requesting a new food vendor - Residents stated food is not satisfactory….” The response to the concern indicated the vendor could not be changed because the vendor was the food supplier for “all VA hospitals.” The minutes did not address alternatives to replacing the food vendor (e.g., purchasing different food items, review of food preparation for possible concerns).
- The 01/17/19 and 02/21/19 Resident Council meeting minutes indicated receipt of “spoiled” food. The response to the concern documented in the 02/21/19 meeting minutes stated, “…to follow up with kitchen line staff.”
- The 03/21/19 Resident Council meeting minutes did not indicate whether concerns identified during the 02/21/19 meeting were resolved.
- The 04/18/19 Resident Council meeting minutes stated, “Veteran reports hot water not hot enough.” Suggestion: “Veteran requests microwave safe cups so residents can heat water in microwave as needed.” In response to the request for microwave safe cups, the minutes indicated staff would look into what supplies could be ordered.
- The 05/16/19 Resident Council meeting minutes did not indicate whether concerns identified during the 04/18/19 meeting were resolved.
- During observations of the evening meal on 08/06/19, several residents did not eat all of the food served. For example, one resident ate two bites of the entrée; the resident later stated the food item tasted “terrible.” On 08/07/19 at 5:15 p.m., a meal tray was tested for temperature and palatability. The temperature of the chicken and dumplings was 110 degrees Fahrenheit (F) and the cooked carrots were 101 degrees F; both items tasted bland.

F371

483.35(i)(2) *The facility must: Store, prepare, distribute, and serve food under sanitary conditions; and*

Level of Harm - No actual harm with potential for more than minimal harm that is not

Based on observation, interview and record review, the CLC did not distribute and serve food under sanitary conditions. Findings include:

The CLC policy titled, “Hand Hygiene,” and dated May 1, 2018, was provided by quality management staff on 08/07/19 at 10:30 a.m. The quality management staff indicated the CLC did not have a separate safe food handling policy. The “Hand Hygiene” policy provided did not address the topic of safe food handling by nursing staff when assisting residents with meals.

immediate jeopardy

Residents Affected - Few

[LOCATION]

- On 08/06/19 at 5:05 p.m., four residents were observed in the dining room. A nursing assistant (NA) was observed visiting with residents prior to delivery of the dinner trays. The NA had his hands in his pockets, scratched his face, and hiked up his pants. Once the trays arrived, the NA, without performing hand hygiene, assisted a resident with his tray. The NA picked up the resident's bread with bare hands to spread the butter. The NA then rubbed his face, put his hands back in his pockets, and hiked up his pants. The NA removed a tray from the cart and took it to a different resident. The NA opened the resident's carton of milk, removed the foil cover from a cup of peaches, and opened the salt and pepper packets. He then unwrapped a straw and touched the end of the straw with his bare hands before putting the straw into the carton of milk. The NA then put his hands back into his pockets, sat down at a dining room table, reached for the hand sanitizer and applied it to his hands.

F431

483.60(e) *Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Based on observation and interview, the CLC did not store all drugs in locked compartments. Findings include:

Medication Administration, [LOCATION]

- During a medication pass observation on 08/07/19, an RN retrieved a spray can of Biotene® mouth spray, liquid acetaminophen, liquid guaifenesin, and liquid calcium carbonate from the medication cart; poured the liquid medications into medicine cups; and placed the medicine cups and the Biotene spray on the top of the medication cart that was positioned by the entrance to Resident #305's room. The RN retrieved a bottle containing simethicone liquid from the medication cart, poured the medication into a medicine cup, and placed the medicine cup and the bottle of medication on top of the medication cart. The RN brought the Biotene spray and all of the medicine cups containing liquid medication, except the cup containing the simethicone, into Resident #305's room at 11:23 a.m. The medicine cup containing the simethicone and the bottle of simethicone liquid, which was approximately one-third full, was left unattended on top of the medication cart while the RN administered the other liquid medications through Resident #305's gastrostomy tube and administered the Biotene mouth spray. The RN's back was toward the medication cart while administering the medications. The RN did not return to the medication cart until 11:37 a.m., leaving the simethicone unattended and out of the line of sight for 14 minutes. Upon returning to the medication cart, the RN noted that the medicine cup containing the simethicone remained on top of the medication cart and indicated the medication would be administered at that time. Before reentering the resident's room to administer the simethicone, the RN placed the Biotene spray can on top of the medication cart next to the bottle of liquid simethicone. At 11:39 a.m., the RN reentered the resident's room to administer the liquid simethicone in the medicine cup through the resident's gastrostomy tube. The RN did not return to the medication cart in the hallway near the entrance of Resident #305's room until 11:43 a.m., leaving the two medications unattended and out of the line of sight for 4 minutes.
- Following the medication administration, the observations were discussed with the performance improvement specialist who accompanied the surveyor and the RN. The performance improvement specialist nodded her head in agreement when it was mentioned that the medications were left unattended on the top of the medication cart.
